HB-0077-0904

STATE OF NEW JERSEY
DEPARTMENT OF THE TREASURY
DIVISION OF PENSIONS AND BENEFITS
NEW JERSEY STATE HEALTH BENEFITS PROGRAM
PO Box 299 Trenton, New Jersey 08625-0299

RESOLUTION

A RESOLUTION to authorize participation in the New Jersey State Health Benefits Program Act of the State of New Jersey.

BE IT RESOLVED:

1. The _____
   Corporate Name of Employer State Social Security I.D. Number
   hereby elects to participate in the Health Program provided by the New Jersey State Health Benefits Act of the State of New Jersey (N.J.S.A. 52:14-17.25 et seq.) and to authorize coverage for all the employees and their dependents thereunder in accordance with the statute and regulations adopted by the State Health Benefits Commission.

2. A. ☐ We elect to participate in the SHBP Prescription Drug Plan defined by N.J.S.A. 52:14-17.25 et seq. and authorize coverage for all employees and their dependents in accordance with the statute and regulations adopted by the State Health Benefits Commission.

   B. ☐ We will be maintaining _____ as our prescription drug plan.*
   Name of Plan

   C. ☐ We will not have a stand-alone prescription drug plan and understand that prescription drug coverage will be provided by the Health Plan.

3. A. ☐ We elect to participate in the SHBP Employee Dental Plans defined by N.J.S.A. 52:14-17.25 et seq. and authorize coverage for all employees and their dependents in accordance with the statute and regulations adopted by the State Health Benefits Commission.

   B. ☐ We will be maintaining _____ as our dental plan.*
   Name of Plan

   C. ☐ We will not have a dental plan.

4. We elect _____* hours per week (average) as the minimum requirement for full time status in accordance with N.J.A.C. 17:9-4.6. *May not be less than 20 hours.

5. As a participating employer we will remit to the State Treasury all charges due on account of employee and dependent coverage and periodic charges in accordance with the requirements of the statute and the rules and regulations duly promulgated thereunder.

6. On adoption of State Health Benefits Coverage for the Health Program, the full cost of dependent coverage will be paid by the employer. ☐ Yes ☐ No If no, _____ percent of dependent coverage will be paid by the employer.

7. We hereby appoint _____
   to act as Certifying Officer in the administration of this program. Name/Title

8. This resolution shall take effect immediately and coverage shall be effective as of _____
   or as soon thereafter as it may be effectuated pursuant to the statutes and regulations. Date

I hereby certify that the foregoing is a true and correct copy of a resolution duly adopted by the:

_____
Corporate Name of Employer

on the _____ day of _____, 20____.

_____
Signature

_____
Official Title

_____
Number of Employees

_____
Street Address

_____
City State ZIP Code

_____
Area Code Telephone

_____
Employer's State Social Security Identification Number

***If not electing Prescription Drug Plan and/or Dental Plan participation, attach copies of current prescription drug and dental plan contracts.**